Overview of the Coordinated Services Team Initiative

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The Children's Charter: Principles from 1938

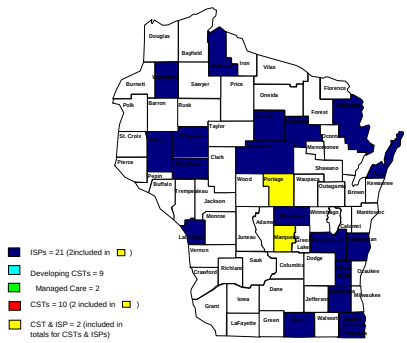
- For Every Child:
  - A home, with love & security that a home provides. When foster care is necessary, the nearest substitute for the child's own home
  - A community which recognizes and plans for the child's needs, provides safe places for play; and provides for cultural & social needs
  - An education which discovers & develops a child's individual abilities & prepares them for a living which yields maximum satisfaction for the child
  - For every child who is physically or mentally handicapped, early diagnosis, provision of treatment, and training so the child may become an asset to society rather than a liability
  - For every child who is "in conflict with society" the right to be dealt with intelligently as society's charge, not society's outcast; with home, school, church & court shaped to return the child whenever possible to the normal stream of life

Adapted from "The Public Assistance Worker"
Russell H. Kurtz, Russell Sage Foundation, 1938

Principles of Collaborative Systems of Care

- Client-centered approach
- Consumer involvement throughout the process
- Building resources on natural and community supports
- Strength-based approach
- Providing unconditional care
- Collaborating across systems
- Using a team approach across agencies
- Being gender/age/and culturally responsive
- Promoting self-sufficiency
- Ensure safety
- Focus on education and employment where appropriate
- A belief in growth, learning and recovery
- Being oriented to outcomes

Wisconsin's Collaborative Systems of Care for Children & Families
(updated 4/05)



Development of a Collaborative System of Care

Stage 1	Different Plans developed separately by each agency involved
Stage 2	Some Plans for a limited number of families are developed jointly, but not all agencies participate
Stage 3	For an increasing number of families, a single Plan incorporates most or all of the services and support activities
Stage 4	Increasing cross-system cooperation allows more and more families to have unified Plans
Stage 5	Wide-scale integration permits unified service planning & delivery, regardless of where the child or family enters the system of care

Elements of an Integrated System of Care, John Franz

Shifts in Beliefs & Attitudes

Participants

From: Hopeless, Self-Blame
To: Hopeful, Understanding

Staff

From: Seeking Deficits, Expecting Little, Knowing Better, Staff Choosing, Power Over
To: Seeing Strengths, Expecting Much, Different knowledge, Families Choosing, Power With

Programs, Agencies, and Communities

From: Conflict and Competition, Crisis Intervention
To: Collaboration, Crisis Prevention

Adapted from Christian Dean, .Cornell, 1993

The Changing Role of Families

- Parents as experts and coordinators for their children's lives
- Parents are partners with members of their team
- Parents as shared or primary service coordinators of their team
- Parents as advocates, service providers, and support for others
- Parents as leaders and consultants

Collaboration with Families

- **Voice:** Parents are listened to and heard in all phases of the planning process
- **Access:** Parents have valid options. No services are withheld for categorical reasons.
- **Ownership:** Parents agree with and commit to any plan concerning them.

Building Trust: Interviews with Parents

- Listen with true concern without judging
- Don't rush decision-making
- Two-way conversation – get to know each other
- Be honest
- Don't pretend to understand if you don't
- Treat participants as equals – acknowledge they know their child best
- Step "into their world" – work with parents where they're at
- If you don't know the answer, say you don't
- Clear Expectations

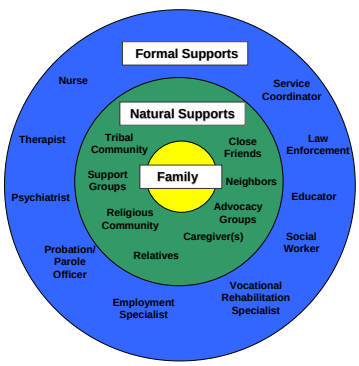
Adapted from interviews between Wisconsin Family Ties advocate, Tina Swinford and parents involved in the CST/ISP process
6/04

Qualifications for Team Involvement

To qualify for team involvement, individuals should:

- Have a role in the lives of the child & family
- Be supportive of child & family
- Be supported for membership by the parent
- Be committed to participate in the process – including regular team meeting attendance
- Participate in discussions
- Be involved in the Plan of Care

Potential Members of Teams



Role of Service Coordinator

- Set Stage for Building Trust
  - Team Rules
  - Roles, Strengths & Goals Exercise
- Assure Team Completes the Summary of Strengths & Needs Assessment and Plan of Care
- Central Team Contact
- Ensure the Plan of Care is Monitored
- Ensure Reassessment and Plan of Care Updates
- Share Outcomes

What's Not the Role of a Service Coordinator

- Sole decision-maker
- Person who does all the work
- The only person team members call
- To dictate what should be done, to infringe on, or be a substitute or the policies and procedures of other agencies

Facilitating Team Meetings: Key Responsibilities

- Open the meeting, welcome team members
- Review and add to the agenda
- Set meeting time limit
- Prioritize agenda items if necessary
- Ensure notes are taken and plan for distribution
- Keep team focused, moving through the agenda
- Keep track of time
- Facilitate discussions and conflict resolution
- Ensure member participation
- Assist team in decision-making
- Set agenda, time, and place of next meeting

When to Use Different Decision-Making Methods

Consensus	Voting
• Use with small groups (10 or less) • When decisions are important or affect a lot of people • The group is informed and individual members feel a similar level of investment	• When it is known that consensus is highly unlikely in the time allowed • Members are equally informed on the subject matter and understand each others' viewpoints • Have a plan for how to keep those who "lose" from becoming defensive
Subgroup	**One Person**
• When the whole group is truly comfortable delegating their authority • When the subgroup has the necessary information and expertise to make the decision	• When it's an emergency • One person has all of the relevant information • One person is especially trusted to make a good decision • The outcome only impacts the decision-maker

Adapted from The Team Handbook; Sholtes, 1996

Levels of Team Involvement

- Assessment, Planning, and Crisis Response Planning
  - Teams meet every 1 – 2 weeks for 45 minutes to 1 hour
  - Phase may last approximately 2 – 3 months
- Plan Implementation & Monitoring
  - Teams meet as often as necessary, typically every 3 – 5 weeks
  - Phase may last approximately 6 – 12 months
- Transition & Closure
  - Teams may meet every 2 – 3 months while transitioning out of the formal team process

Summary of Strengths & Needs

- Living situations
- Basic needs and financial status
- Child & family situation
- Mental health
- Social interaction
- Access to community resources
- Cultural involvement
- Spiritual status
- Educational/vocational status
- Legal involvement
- Medical status
- AODA status
- Crisis response

CST Summary of Strengths & Needs Assessment

Legal Domain		
	Level of need (1=no need, 5=great need)	Area of Strength?
1. Describe significant involvement with legal system and current status: In February 2001, Jon broke a door at school when he slammed it out of anger. City police were contacted by the school and the incident was reported to Human Services. An informal arrangement was worked out between the family and school – Jon will serve 20 hours of community service at the school and pay $200 restitution by February 2002.	1 2 3 4 5	☐ Strength?
Other Strengths: Over the summer, Jon saved $75 toward restitution	***Other Needs:*** Explore options for community service activities at school, including supervision	

Plan of Care Development

- The service coordinator schedules meetings with the family team to develop the plan
- The team reviews process principles, and identifies the strengths of the individual and team member.
- The team reviews each domain, identifying strengths, needs, and the child's current level of functioning.
- The team prioritizes the needs
- The team develops the Plan of Care to include:
  - The child's present level of functioning
  - The goals, objectives and activities
  - Who will be involved
  - How services will be paid for
  - How outcomes will be evaluated

Sample Plan of Care Page
Mental Health Domain

Identified Need	Strengths Related to Need	Outcome/Goal	Activities (who, what, when, $)	Progress
Organization of medications and important documents (prescription & MA info)	Mom has a very good memory Aunt Sue has helped clean & organize home Billy likes to draw Mom & Billy have good relationship with therapist	Billy's medications and important documents are organized. Family has a plan to maintain the organization.	Mom will get updated list of meds and dosages from therapist on 5/17. Next Sat (5/22) aunt Sue will help clean & organize the kitchen (where meds are kept) Mom & Billy will create a chart or creative labeling system (Billy artist) by 5/31 SC will check w/ family weekly to monitor how the organization plan is going	Date Scale 1 – 5

Crisis Response Plan Development

"A crisis occurs when adults don't know what to do." **– Carl Shick**

- Expect that a child with multiple needs living in the community will experience crisis.
- Consider the most challenging act(s) that could happen
- Review historical strength-based information regarding strategies that have worked
- Pre-plan interventions with people and/or agencies who may be involved in the safety issue
- Develop a protocol of who will be notified, in what time frame, including responsibilities and communication procedures
- Establish a "blame free" time in which team members cannot fault each other for the crisis
- Develop a process for evaluating the crisis response plan's use within two weeks of the event.

Barriers to Collaboration

- I don't have signed releases to share or obtain information
- There's no money available to pay for services for needs identified in the Plan
- If I make an exception for one child, it wouldn't be fair for the others
- My workload is too large – I don't have time!
- My boss is pressuring me to stay in the office & increase "face-to-face" time
- I've never been involved in Wraparound and don't know anything about it
- I've been involved before – it wasn't beneficial
- I must maintain professional boundaries with clients
- I can't stand working with that person/agency!

Principles for Conflict Management

- Encourage equal participation: we are in this together
- Actively listen: you are important and valued
- Separate fact from opinion: challenge categorical statements
- Separate people from the problem: use the board
- Focus on the big picture: reaffirm goals, principles, values
- Build consensus

Adapted from Conflict Management, Hendricks, 1989

Key Stages in Collaborative Negotiation

- Identify and define the problem
- Understand the problem fully – identify interests and needs
- Generate alternative solutions
- Evaluate and select the resolution option

Evaluation

- Plan of Care
- Quarterly Reports, includes data related to:
  - Education, juvenile justice system involvement, restrictiveness of living environment, mental health, and cost
- Family & Team Member Closure Surveys
- Service Provider Evaluation
- State Family Satisfaction Survey
- Statewide Annual Report

Transition Out of the Process

- The intent of the team is *not to solve every problem* that the family or the providers have, rather to *develop skills, gain knowledge and identify and access resources necessary to* ***meet the needs***.
- Once this process is working and doesn't necessitate team support, the formal team process should end.
- This doesn't mean that services aren't necessary or that supports aren't needed. It simply means the family has *voice, access and ownership*.

The Coordinating Committee Suggested Membership

- Human Services representing AODA, mental health, developmental disabilities, family support, child welfare, and juvenile justice systems
- Consumers/individuals representing the target population (min 25% of membership)
- Representation from:
  - Education – School Districts, CESA, School Board, Head Start
  - Health Department
  - Domestic Violence Program
  - Law Enforcement
  - Probation & Parole
  - Vocational/Technical School
  - Clergy
  - County Board
  - UW Extension
  - Private Business
  - Additional Community Groups as desired

The Coordinating Committee Suggested Responsibilities

- Prepare Interagency Agreement; renew every 3 years
- Assess how the program relates to other service coordination programs, taking steps to avoid duplication of services
- Identify and address gaps in service
- Be involved in the review (screening) of referrals
- Establish operational policies & procedures; ensure they are monitored and adhered to
- Ensure quality, including consumer & agency satisfaction
- Plan for sustainability of the system change – beginning year 1
- Ensure any realized savings from substitute care budgets are reinvested in the community-based CST process
- Establish target group to be served
- Be a liaison to the agency/group you represent on the committee
- Attend and participate in Committee meetings and activities

Key Elements in an Interagency Agreement

- Evaluation processes State mission & principles
- Define the persons to be supported (target group)
- Define partner roles & responsibilities
  - At the family team level
  - Of individuals on the Coordinating Committee
  - Agency role & responsibilities (e.g. referral, funding, system change)
- Define the process for accessing & delivering services
- Define the process for paying for services
- Define the conflict management process
- Define evaluation process

Sampling of Outcomes/Benefits

- Advocacy & informal support services are available to families
- Communication, collaboration, and coordination have improved in responding to the needs of other participants
- Other funding sources have been leveraged:
  - Child abuse and neglect prevention
  - Safe and Stable Families
  - Targeted case management & intensive in-home therapy
  - Other grant and foundation funds requiring collaboration
- Funds have shifted to lesser cost alternatives/pooling of funds
- Several beneficial workshops/trainings have been provided
- Less duplication of services, workload is shared
- A shift toward outcome-based activities has occurred
- Family involvement in development, implementation, and evaluation of activities has resulted in more "community ownership" of process

A Summary of Steps for Developing a Collaborative System of Care

- Identify partners & develop polices
- Determine target population
- Determine process for referral & enrollment
- Identify and train service coordinators
- Implement the team process
- Establish monitoring & evaluation processes
- Ensure sufficient collaborative funding
- Develop a collaborative plan for sustainability

Wisconsin's Collaborative Systems of Care (WCSOC) Resource Website

- Core Values
- Trainings & Events
- Handbooks
- Consumer Resources
- Partner Resources

www.wicollaborative.org